UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

SOLIRIS(eculizumab)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Physician NPI:_____

Phone#:_____Ext.and options_____Fax#_____

All information to be legible, complete and correct or form will be returned

FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO (801) 536-0477

CRITERIA:

- Documented diagnosis of paroxysmal nocturnal hemoglobinuria.
- Documented failure of or intolerance to other PNH treatments, including transfusion.
- Review by the DUR Board.

INFORMATION:

To be given in clinic setting only. Patients with HMO's (except IHC) will have to make arrangements with their HMO for coverage. Provider will bill with J code J3490, NDC number, and PA number.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

1 year with updated letter of medical necessity and documentation of patient progress.